



Underwritten by Coventry Health Care of Louisiana, Inc.

CoventryOne
Received Date: _____

Coventry Health Care of Louisiana, Inc. LA

Application for Health Coverage

Important: Please print clearly in BLACK ink as instructed in each section. Initial and date corrections; correction fluid is not permitted. Read and sign the Acknowledgements Section on page 6.

NOTICE - YOU MUST PERSONALLY BEAR ALL COSTS IF YOU UTILIZE HEALTH CARE NOT AUTHORIZED BY THIS PLAN OR PURCHASE DRUGS WHICH ARE NOT AUTHORIZED BY THIS PLAN.

Submit completed Application for Health Coverage to:
CHCLA, 3838 North Causeway Blvd.,
Suite 3350, Metairie, LA 70002 Or, by
fax to: (866) 560-6328

Check all that apply:

- New Application Add a Dependent Plan Benefits Increase Child-Only Application (under 18 years old)

Plan Choice Choose one (1) plan only. If other individuals applying for coverage wish to apply for different plans, a separate Application must be used.

POS COPAY PLANS

- POS Copay 500
- POS Copay 750
- POS Copay 1000
- POS Copay 1500
- POS Copay 2500
- POS Copay 5000

POS COPAY VALUE PLANS

- POS Copay Value 500
- POS Copay Value 1000
- POS Copay Value 2500
- POS Copay Value 5000
- POS Copay Value 7500

Choose a pharmacy option for your POS Copay Value Plan

- Rx Plan A = \$500 Rx deductible
- Rx Plan B = \$1000 Rx deductible

HSA QUALIFIED HIGH-DEDUCTIBLE HEALTH PLANS

- HDHP \$1700/0%
- HDHP \$1700/20%
- HDHP \$2500/0%
- HDHP \$2500/20%
- HDHP \$5000/0%
- HDHP \$5000/20%
- HDHP Universal \$2500/0%
- HDHP Universal \$2500/20%

If you have selected a CoventryOne Qualified High-Deductible Health Plan (QHDHP), you are eligible to open a Health Savings Account (HSA) through our HSA trustee, Health Equity, upon approval.

I elect to have an HSA opened through HealthEquity

Requested Effective Date: 1st day of _____ 20____

Requested Effective Date must be after, but no MORE than sixty days past the signature date of the Application. Requested Effective Date is not guaranteed.

Amount quoted for Requested Effective Date: \$_____ / Month Individual Family

Note: The amount quoted is an estimated cost of the selected health plan, which is subject to change based on medical history, the underwriting process, and, if any, other relevant factors.

Primary Applicant Information Please provide information on the Primary Applicant. If applying for Child-Only coverage, please fill in the parent or legal guardian's information below.

Last name	First name			MI	Primary phone number () -
Home address	City	State	ZIP	Parish	
Mailing address (if different from address above)	City	State	ZIP	Best time and phone number to receive a call regarding this Application, if necessary: <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Anytime (8am-8pm) () -	
E-mail address (if we may correspond with you via E-mail)	<input type="checkbox"/> Check here to consent to receiving your policy and other pertinent documents by e-mail only				
Relationship (if Child-Only Application)	Occupation / Title				

Primary Applicant Name: _____
GSA LA COV1 042010

Agent: Patricia Freeman _____

Applicant and Dependent Information

General Information List all individuals applying for health coverage in this section. For a Child-Only Application, begin listing child(ren) on Line 3 with the youngest child listed first. If you need more space, attach a separate sheet of paper with the details in the same format as the box below. Sign and date any attachments.

	Full Name (Last, First, MI)	Social Security Number	Birthdate (mm/dd/yyyy)	Gender (M or F)	Height (ft. in.)	Weight (lbs.)	Tobacco use in past 12 months? ¹	U.S. residency for past 6 months ²
1	Primary Applicant (blank if Child-Only)						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2	Spouse (blank if Child-Only)						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Home address (if different from Primary Applicant)							
3	Dependent Child or Child-Only						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Home address (if different from Primary Applicant)							
4	Additional Child						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Home address (if different from Primary Applicant)							
5	Additional Child						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Home address (if different from Primary Applicant)							
6	Additional Child						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Home address (if different from Primary Applicant)							

¹ 'Tobacco use' constitutes use of tobacco or tobacco cessation products in the past twelve (12) months. ² 'U.S. residency' refers to the designated individual living legally in the United States for the past 6 months.

1 Prior Insurance Coverage	
Has any individual applying for coverage had any health insurance coverage in the past 2 years? If "Yes," list names, start and end dates below. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
2 Pre-Existing Condition Credit	
Does any individual applying for coverage have proof of prior creditable coverage without a break in coverage of 63 days or more, and would like to use it to credit any pre-existing condition limitation? Using your creditable coverage credit may result in an adjustment to your quoted rate. If "Yes," you must include a copy of the creditable coverage document(s) / Certificate of Creditable Coverage. You may be subject to a pre-existing condition exclusion until Coventry receives these documents.	<input type="checkbox"/> Yes <input type="checkbox"/> No

Patricia Freeman

Primary Applicant Name: _____
GSA 012010

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Agent Name: _____

Medical Information The Medical Details section requires your careful attention to each question. The questions below should be answered by you and not by any broker representing you. If you fail to provide truthful or accurate health history information you may lose your coverage or other penalties may apply. You may want to consult your physicians if you have questions regarding the information requested below.

Answer questions on behalf of all individuals applying for coverage. Each individual applying for coverage needs to provide his or her own medical history. Only provide a family member's medical history if the family member is also applying for coverage on this Application. A person applying for coverage does not need to provide any genetic information (including genetic testing, genetic counseling, or genetic education).

Check "Yes" or "No," and provide additional information in the Medical Details section when necessary.

1 Physical Exam

Has any individual applying for coverage had a physical or wellness exam within the past 2 years?
If "Yes," provide details in the Medical Details section on page 5.

Yes No

2 Pregnancy

Is any individual applying for coverage currently pregnant, expecting a child with anyone, an expectant or surrogate parent, or in the process of adopting a child?

Yes No

3 Transplants

Has any individual applying for coverage been a candidate or recipient of an organ or bone marrow transplant?
If "Yes," provide details in the Medical Details section on page 5.

Yes No

4 HIV / ARC / AIDS

Has any individual applying for coverage ever tested positive for Human Immunodeficiency Virus (HIV) or been diagnosed as having AIDS Related Complex / Conditions (ARC), Acquired Immunodeficiency Syndrome (AIDS) or any other medical condition / disorder derived from such infection or immunodeficiency?

Yes No

Check all that apply. In the past 5 years, has any individual applying for coverage experienced or been experiencing any persistent pain or symptoms, had symptoms of, been treated or tested for, been advised to have treatment or testing for, been hospitalized for, had surgery for, taken medication for, or been advised that they have or may have had any of the following? If nothing in a category applies, select the "None" box. Provide details for all checked items (including "Other") in the Medical Details section on page 5.

5 Cancer / Cyst / Tumor

Carcinoma, sarcoma, leukemia, lymphoma, myeloma, central nervous system cancers or carcinoma in situ

Cyst, growth, lump, mass, tumor or polyp

Other

None

6 Respiratory System

Allergies or asthma

Emphysema or chronic lung disease (COPD)

Sleep apnea

Other

None

7 Cardiovascular and Circulatory System

Hypertension or high blood pressure

Deep Venous Thrombosis or phlebitis

Varicose veins, blood clot or aneurysm

Irregular heartbeat, heart murmur, or mitral valve prolapse

Heart attack, chest pain or angina

Other

None

8 Digestive System

Chronic abdominal pain, ulcer, acid reflux or hiatal hernia

Diverticulitis, diverticulosis, hemorrhoids, or hernia

Disorder of the esophagus, stomach, colon, rectum, intestine, bowel, gallbladder or pancreas

Liver condition or hepatitis A

Cirrhosis, fatty liver or hepatitis B or C

Surgical treatment for obesity, gastric bypass or banding

Other

None

9 Emotional or Mental Health

Anxiety or depression

Attention Deficit Disorder or Attention Deficit Hyperactivity Disorder

Bipolar disorder

Obsessive Compulsive Disorder, schizophrenia

Eating disorder

Therapy or counseling

Other

None

Primary Applicant Name: _____
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Agent Name: Patricia Freeman

10 Muscular or Skeletal System		
<input type="checkbox"/> Bursitis, tendonitis or gout <input type="checkbox"/> Disorder of the back, neck or spine <input type="checkbox"/> Connective tissue disorder, systemic lupus, rheumatoid arthritis <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Disorder of the knee, shoulder, hip or other joint	<input type="checkbox"/> Osteoarthritis, osteoporosis or osteopenia <input type="checkbox"/> Temporomandibular joint disorder (TMJ) <input type="checkbox"/> Fractures or broken bones <input type="checkbox"/> Prosthetic limbs or devices, or internal fixations (pins, plates, screws) <input type="checkbox"/> Any chiropractic treatments <input type="checkbox"/> Other	<input type="checkbox"/> None
11 Skin		
<input type="checkbox"/> Acne or rosacea <input type="checkbox"/> Eczema or psoriasis	<input type="checkbox"/> Abnormal or cancerous moles, melanoma <input type="checkbox"/> Other	<input type="checkbox"/> None
12 Eyes / Ears / Nose / Throat		
<input type="checkbox"/> Disease or injury of eye <input type="checkbox"/> Cataracts or glaucoma <input type="checkbox"/> Ear disorder, ear infections or tubes in ears <input type="checkbox"/> Hearing loss or cochlear implant	<input type="checkbox"/> Deviated septum or sinus infection <input type="checkbox"/> Disorder of the throat, tonsils or adenoids <input type="checkbox"/> Other	<input type="checkbox"/> None
13 Kidney or Urinary Tract		
<input type="checkbox"/> Bladder or urinary tract infection or disorder <input type="checkbox"/> Kidney infection or disorder	<input type="checkbox"/> Kidney or bladder stones <input type="checkbox"/> Other	<input type="checkbox"/> None
14 Female Reproductive System		
<input type="checkbox"/> Disorder of the breast or abnormal mammogram <input type="checkbox"/> Saline breast implants <input type="checkbox"/> Silicone breast implants <input type="checkbox"/> Abnormal Pap smear <input type="checkbox"/> Endometriosis, uterine fibroids or uterine prolapse	<input type="checkbox"/> Infertility or complications of pregnancy <input type="checkbox"/> Menopausal disorder <input type="checkbox"/> Menstrual disorder <input type="checkbox"/> Cervical, ovarian, uterine or vaginal disorder <input type="checkbox"/> Other	<input type="checkbox"/> None
15 Male Reproductive System		
<input type="checkbox"/> Infertility <input type="checkbox"/> Penile or testicular disorder	<input type="checkbox"/> Prostate disorder, elevated PSA, Prostatitis <input type="checkbox"/> Other	<input type="checkbox"/> None
16 Sexually Transmitted Diseases		
<input type="checkbox"/> Chlamydia <input type="checkbox"/> Genital warts <input type="checkbox"/> Genital herpes	<input type="checkbox"/> Human Papilloma Virus (HPV) <input type="checkbox"/> Gonorrhea or syphilis <input type="checkbox"/> Other	<input type="checkbox"/> None
17 Blood / Adrenal / Endocrine / Pituitary / Thyroid		
<input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Elevated blood sugar <input type="checkbox"/> Elevated cholesterol or triglycerides	<input type="checkbox"/> Endocrine, adrenal, or pituitary disorder <input type="checkbox"/> Weight disorder <input type="checkbox"/> Thyroid disorder <input type="checkbox"/> Other	<input type="checkbox"/> None
18 Brain or Nervous System		
<input type="checkbox"/> Concussion or head injury <input type="checkbox"/> Migraines or chronic headaches <input type="checkbox"/> Convulsions, seizures, epilepsy, fainting, tics or tremors	<input type="checkbox"/> Stroke, Transient Ischemic Attack (TIA) or paralysis <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> Other	<input type="checkbox"/> None
19 Congenital or Development		
<input type="checkbox"/> Cleft palate or cleft lip <input type="checkbox"/> Developmental disorder or delay	<input type="checkbox"/> Mental retardation, autism, or Down's Syndrome <input type="checkbox"/> Other	<input type="checkbox"/> None
20 Alcohol / Drug		
<input type="checkbox"/> Alcohol abuse, dependency or alcoholism <input type="checkbox"/> Drug / substance abuse or dependency	<input type="checkbox"/> A citation or conviction for driving under the influence of alcohol or any drug / substance <input type="checkbox"/> Other	<input type="checkbox"/> None
21 Other Conditions		
<p>In the past 5 years, has any individual applying for coverage experienced or been experiencing any persistent pain or symptoms, had symptoms of, been treated or tested for, been advised to have treatment or testing for, been hospitalized for, had surgery for, taken medication for, or been advised that they have or may have had any other condition(s) not listed on this Application? If "Yes," provide details in the Medical Details Section on page 5.</p>		<input type="checkbox"/> Yes <input type="checkbox"/> No

Primary Applicant Name: _____
GSA 012010

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Agent Name: Patricia Freeman

Medical Details Please provide COMPLETE details for all questions with a "Yes" answer or a checked box in the Medical Information section. Provide the question number you are referencing in the first column. If you need more space, **attach a separate sheet of paper** with the details in the same format as the box below. Sign and date any attachments.

Q#	Name of Individual Applying for Coverage (Last, First, MI)	Explain Nature of Illness / Condition (include results of any physical exam)	Date of Onset (mm/yy)	Date of Recovery (mm/yy)	Remaining or Ongoing Symptoms or Treatment
	Treating Physician's Name	Address	Phone Number		
	Treating Physician's Name	Address	Phone Number		
	Treating Physician's Name	Address	Phone Number		
	Treating Physician's Name	Address	Phone Number		
	Treating Physician's Name	Address	Phone Number		

Medications Please provide COMPLETE details for all medications (prescription or over-the-counter) currently being taken or that have been taken by (including samples), or were prescribed or recommended for, any individual applying for coverage in the past 12 months. If you need more space, **attach a separate sheet of paper** with the details in the same format as the box below. Sign and date any attachments.

Name of Individual Applying for Coverage (Last, First, MI)	Date Started (mm/yy)	Date Discontinued (mm/yy)	Medication Name	Dosage and Frequency	Condition / Reason for taking

Primary Applicant Name: _____
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Acknowledgements

By signing this Application form, I, the Applicant, including any undersigned Spouse and Dependents, agree to the following statements:

- I understand that all individuals applying for health coverage listed on this Application are subject to medical underwriting review. I understand that the selling agent (if applicable) has no authority to promise coverage to the applicant or any individual applying for coverage, or to modify Coventry's underwriting criteria or terms of coverage.
- I understand that the information that I provide on this Application will be used to determine whether Coventry accepts my Application and so provides me with a policy of health coverage for which I'm applying. I attest that my Application responses are complete and accurate to the best of my knowledge.
- I understand that if any material information is omitted or misrepresented from any section of the Application, coverage may be refused, terminated, or rescinded, at Coventry's sole discretion. In the event that coverage is rescinded, the policy will be voided back to the original effective date and all premium payments will be refunded. Coventry shall not be financially liable for any health care services rendered prior to the rescission.
- I agree to notify Coventry in writing if I or any individual applying for health coverage receives any new diagnosis, treatment, or health service, or if any of the answers or statements provided on this Application change between the date this Application is signed and the effective date or approval date of coverage, whichever is later. My failure to provide Coventry with this updated health information may result in a denial or rescission of coverage.
- I understand that if any individual applying for coverage is declined for coverage, that individual may not re-apply for Coventry *One* coverage for six (6) months from date of signature.
- I understand that this Application is valid for sixty (60) days from the earliest date of signature in the Acknowledgements section.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

DO NOT cancel your existing insurance coverage until an offer of coverage has been extended by Coventry in writing. Please retain a copy of this application for your records.

Primary Applicant's Signature	Date	Spouse's Signature (if applying for coverage)	Date
Dependent Signature ¹	Date	Dependent Signature ¹	Date

The below signatures must be completed if this is a Child-Only Application or if any child applying for health coverage (under the age of 18) has a Custodial Parent² that is not the Primary Applicant or Spouse of the Primary Applicant.

Parent/Legal Guardian Signature	Print Name	Relationship to individual applying for coverage	Date
Custodial Parent Signature ²	Print Name	Name of child(ren) to whom this applies	Date

¹ Dependent Signature is required for individuals applying for coverage ages 18 and over

² The 'Custodial Parent' is the person with physical or legal custody of a child under 18 years of age.

FOR AGENT USE ONLY

Agent Certification: I am not aware of any other information which may have a bearing on the insurability of anyone to be covered and have not altered any responses recorded on this Application or any supplement to it. I have not advised any individual applying for coverage to withhold any information regarding the answers to the questions and have advised the individuals applying for coverage to review the Application and the answers recorded to confirm completeness and accuracy. I further attest that all my answers recorded in this application are correct, complete, and wholly true to the best of my knowledge and belief.

Agent name	Agent ID#	Agent E-mail
Agency name	Agent / Agency phone	Name of General Agent
Payee (who is paid commissions) <input type="checkbox"/> Agent <input type="checkbox"/> Agency <input type="checkbox"/> General Agent	Payee Tax ID#	
Agent Signature	Date	

Primary Applicant Name: _____
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Agent Name: Patricia Freeman

Premium Payment

Premium Payment Choose ONE payment option. You must then complete the applicable sections regarding your account information.

Monthly EFT (no administrative fee)

Payroll Deduction Program This program allows your premium to be deducted directly from your paycheck, post-taxes. Other details apply. To choose this option, you **MUST** submit a separate *CoventryOne* Payroll Deduction Authorization Form with your Application.

NEW Payroll Deduction Program (PDP) EXISTING Payroll Deduction Program (PDP)
 PDP number: _____ PDP name: _____

EFT (Electronic Funds Transfer) Information Complete this section if you have chosen to pay by EFT. The monthly premiums shown above will be withdrawn automatically from the bank account listed on the Application on the 10th day (or next business day if a weekend or holiday) of the month for which premium is due. The premium amount due is calculated per day, so if the effective date is anything other than the 1st of the month, the initial premium will be prorated.

<input type="checkbox"/> Checking Account	Name of account holder	9-digit routing number						Account number
<input type="checkbox"/> Savings Account								
Name of bank / savings institution		Relationship of account holder to Primary Applicant						
		<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other _____						
Account holder address		City				State	ZIP	

Important Note: *CoventryOne* is not an employer-sponsored group health plan. If your banking information is from a business account, or you are submitting a check drawn from a business account, you must contact your agent to complete a *CoventryOne* Payroll Deduction Authorization Form.

- By signing this Premium Payment section, you are agreeing to the following statements:
- You understand that it is your responsibility to notify Coventry Health Care of Louisiana at 1-866-364-5663 should your payment information change at any time while you continue to hold a *CoventryOne* policy.
 - You understand that if premium payment is returned unpaid, a fee will be assessed in the amount of \$20.00. You authorize Coventry Health Care of Louisiana to collect the premium payment due between the 20th and 30th of the month, including any unpaid fee amount. Failure to remit the first payment rescinds the policy.
 - You understand that providing this payment information does not guarantee approval or coverage.
 - Upon approval and acceptance of this Application, you authorize Coventry Health Care of Louisiana to initiate automatic withdrawal and / or a billing cycle of applicable premium payments from your provided account or billing information. If your effective date is entered into the system after the third business day of the month, your first automatic withdrawal may include premium amounts for multiple months.

Account / Card Holder Signature: _____ Date: _____

Authorization of Release of Information

I, the Applicant, for myself and any of my Dependents who are under the age of 18 and who are applying for coverage hereunder, hereby make the following authorizations:

I authorize any physician, medical professional, hospital, clinic, pharmacy, pharmacy benefits manager or other pharmacy related services organization, health plan, insurance company, claims administrator, employer, governmental agency or other person or firm, to disclose to Coventry Health Care of Louisiana or its authorized representatives, my (or my Dependents') personal information, including copies of records concerning physical or mental illness, advice, diagnosis, prognosis, prescription information, care or treatment provided to me, including without limitation, information relating to autoimmune deficiency syndrome (AIDS), human immunodeficiency virus (HIV), or the use of drugs or alcohol. I also authorize the release of information relating to mental illness.

In addition, I authorize Coventry Health Care of Louisiana to review and research its own records for information. I understand my authorization is voluntary and that such information will be used by Coventry Health Care of Louisiana for the purpose of evaluating my Application for health insurance. Further, I understand that my authorization is required for Coventry Health Care of Louisiana to consider my Application and to determine whether or not an offer of coverage will be made. No action will be taken on my Application without my signed authorization. I understand information obtained with my authorization may be re-disclosed by Coventry Health Care of Louisiana as permitted or required by law and may no longer be protected by the federal privacy laws. I understand that I or any authorized representative will receive a copy of this authorization upon request.

I authorize Coventry Health Care of Louisiana to use or disclose the information I provide in this Application (or that the Coventry Health Care of Louisiana has or receives from third parties) for purposes of administering my health insurance benefits. This authorization is valid from the date signed until revoked by me in writing (which I may do at any time) or such shorter period required by law. Any revocation will not affect the activities of Coventry Health Care of Louisiana prior to the date such revocation is received by Coventry Health Care of Louisiana.

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

_____ Primary Applicant's Signature	_____ Date	_____ Spouse's Signature (If applying for coverage)	_____ Date
_____ Dependent Signature* *Required age 18 and over.	_____ Date	_____ Dependent Signature*	_____ Date
The below signature must be completed if this is a Child-Only Application.			
_____ Parent/Legal Guardian Signature	_____ Print Name	_____ Relationship to child applying for coverage	_____ Date

Primary Applicant Name: _____
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Agent Name: Patricia Freeman